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Reprinted from the Montreal Medical Journal, January, 1897.

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We cannot take up any medical journal, but we find papers by able writers, on almost every subject, connected, in even the remotest way, with medicine and surgery : but very often the essays, however ably written, do not affect the treatment we give in our cases, for often we have forgotten the subject matter of an essay, before a case, occurring in our own practice, brings the points forcibly to our minds ; for one case, under our own care, teaches us more than reading about 100 similar cases.

Therefore to-night I simply want to relate a few cases, that have come under my own observation, in which we shall see serious traumatic and pathological lesions have occurred, without the threatening symptoms which most text books lead us to think must occur, in order to have the lesions present. The reason for this is obvious ; there is a strong tendency for one writer to quote an older one as an authority, and often errors are in this way perpetuated in medicine, as they are in law, by looking for precedent.

We are accustomed to think that as soon as a perforation of the intestine occurs, in typhoid for instance, that immediately we have severe abdominal pain which develops in the right iliac fossa and rapidly spreads over the whole abdomen. Profound collapse ; the latter evidenced by feeble running pulse, cold sweat, and subnormal temperature, feeble respiration, great thirst, suppression of urine and frequent vomiting. Now these symptoms, as we know, do occur : that from autopsies I have seen I have reason to believe that they do not set in until from 6 to 12 hours after the rupture, and that the symptoms are then due, not primarily to the rupture, but to the resulting peritonitis. There is no symptom which is, of itself, evidence of a perforation of the intestines, either traumatic or pathological. Rupture of any of the internal viscera is not necessarily accompanied by severe symptoms immediately ; nor even in severe accidents do we at once get evidence of damage done. Hence, how often do we read in the daily papers, as the opinion of some doctor in an accident case, that a patient will recover, " unless he has been injured internally." Warren, in his text-book on " Surgical Pathology

[1] Read before the Rochester Pathological Society, December 17, 1896.

and Therapeutics," refers to this under the head of insidious shock, in which he says : " The person, though seriously injured, congratulates himself upon having made an excellent escape, and imagines that he is not only in no danger, but will soon be about again."

" The countenance, in this form of shock, has often a peculiarly melancholy expression, as if foreshadowing the fatal event ; a sad smile plays upon the lips, and illumines the lower part of the face, while the upper part wears a gloomy aspect, in striking contrast to the other. It seems in such cases, that there had been an attempt at reaction, which had failed. The cheek may be flushed slightly, and the skin be dry and warm, but the pulse, although strong, is easily compressed, and it is evident to the careful observer that the patient's condition is most critical. He may greet you with a cheerful " Good morning, Doctor," and when asked how he feels, will respond, " fine," and yet the fatal end may come only a few hours later."

The following case will illustrate the point.

On October 27, 1894, I was hurriedly called to see a young man, aged 17, who had accidentally shot himself with a 22-calibre Flobert rifle. He was shooting rats in the rear of the house, and in some way discharged his rifle while it was pointing towards him. The gun was nothing more than a toy, being what boys commonly use, and his father, who came for me, thought that his son had only received a slight flesh wound. The patient, after his injury, walked from the yard up one flight of stairs to his bed, and when I saw him, I found the following condition. A ragged, bruised tear, extending longitudinally along the left side of the penis ; a small oblique wound in the left groin, about half an inch above Poupart's ligament ; one inch nearer to the symphysis pubis than to the anterior superior spine of ilium.

The patient was a muscular young man, and did not consider himself seriously hurt, his pulse was full, strong, and regular, and beat about 72 to the minute. He said he felt no pain whatever, his colour was good, nor was there any anxiety expressed on his countenance. There was no bleeding from the wound, and my impression at the time, judging from his condition, and the history of the case, was that we had probably a mere flesh wound, but, on running my probe into the bullet hole, I found that it entered the abdominal cavity. I advised immediate laparotomy and took the boy at once in a hack to the City Hospital. About an hour elapsed before everything was in readiness for an exploratory incision, and even when put upon the table, the patient was in good condition. I made an incision about 3 inches long, extending upward from the wound, and on opening the

peritoneal cavity, a sudden gush of bright red blood showed injury to a large vessel. After some delay, owing to the extent of the hæmorrhage, I succeeded in securing the artery, which was a branch of the inferior mesenteric. On carefully drawing out the intestines, I found eleven distinct holes, allowing fæcal contents to escape. These punctures bled profusely but were rapidly sewed up, with the assistance of some of the gentlemen present here this evening. One piece of ileum was so badly lacerated that I performed a resection, removing over three inches of the gut, and putting in a Murphy button. I now thought I had discovered all the injuries, but there being some evidence of further hæmorrhage, I enlarged the incision in an upward direction, and discovered a tear, about four inches long, which separated the descending colon from the meso-colon. This laceration being sewn up, and all apparent hæmorrhage stopped, the peritoneal cavity was very carefully cleansed and the wound closed. The patient never rallied, and died four hours after the operation, and about seven hours from the time of the accident. A partial autopsy being allowed, and feeling sure there was further hæmorrhage, I found, in addition to the injuries already described, that the bullet had buried itself in the spleen, from which there had been free bleeding, which burrowed down in the cellular tissue, toward the left kidney.

When we consider the extent of these injuries, it hardly seems possible that the patient had such slight symptoms, even an hour after his injuries.

A few weeks previous to the case just related, an Italian was shot in a saloon on West Avenue, the bullet entering the belly. He was removed to the City Hospital, but as he did not exhibit any signs of internal hæmorrhage, or of perforation, the attending surgeons thought it best to wait for symptoms calling for interference. About 36 hours after entering the hospital, he began to have symptoms of peritonitis, A laparotomy was then undertaken, and several punctures found, which were carefully sewn up, but the patient died of general peritonitis. Might he not possibly have been saved if an immediate operation had been done ?

On the evening of May 9th, 1894, Dr. E. W. Mulligan sent me to make a call for him. I found a boy, aged 12 years, suffering with a bearing down pain over the bladder, and making ineffectual attempts to urinate. His parents said that he had complained of some pain for five or six days, but was not so bad as to interfere with his play, and they did not consider it necessary to send for a physician, but as he had not urinated all that day, they thought it time to have a

doctor "draw his water," as they expressed it. On examining the boy, I discovered an ovoid tumour, extending almost up to the umbilicus. On gentle percussion, it gave an absolutely flat sound. The belly was somewhat tender, but not markedly so. As I did not have a catheter with me, and the boy was very uneasy, I gave him a hypodermic injection of morphine, and went back to my office for a catheter. When I returned to the house, his mother told me that there was no need to pass a catheter as he had urinated some and felt all right; but on looking in the vessel I saw he had only passed a couple of drachms of urine. Feeling positive there was more urine than that in the bladder I examined the abdomen again, but was surprised to find that the tumour had entirely disappeared. I then passed a small soft rubber catheter, but succeeded in getting only a few drops of urine. The boy was very comfortable, did not complain of pain, but was tender all over the belly and had a temperature of 103°. Feeling sure the bladder had ruptured, I sent for Dr. Mulligan, and he saw the case about midnight. He urged immediate laparotomy, and took the child in his carriage to the City Hospital, made a median incision and found the abdomen full of fluid. The doctor discovered a small tear at the apex of thebladder which extended into the peritoneal cavity. He sewed the tear up and in washing out the peritoneal cavity found a gangrenous appendix, which he removed and the patient made a good recovery.

Here was a boy then with appendicitis, running around playing, suffering with a reflex retention of urine, subsequently having a spontaneous rupture of the bladder, with but little discomfort, and no symptoms of shock.

One Friday evening in January, 1895, a young man, a personal friend of mine, came into the office, complaining of pain in his right side. On examination I found there was slight tenderness over McBurney's point; no rise in temperature, nor in the rate of the pulse. As he was constipated, I ordered a purgative, told him to go home to bed and not to get up in the morning unless he felt better. On seeing him next morning, his bowels had not moved. He was uneasy but not suffering much pain; temperature and pulse normal. Ordering a large dose of castor oil and hot stupes, I left. When I saw him that afternoon, he was sitting up in bed reading the paper. His bowels had moved, and he felt quite comfortable, saying he was just waiting for my consent to get up and go skating: but I noticed his eyes were slightly jaundiced, and that his temperature had risen to 101° with a slightly more rapid pulse. The tenderness over McBurney's point was better, except on deep pressure and there was no rigidity of the

muscles of abdomen. I had difficulty in persuading him to allow me to have counsel, as he did not consider himself sick. Dr. Mulligan saw the case with me later in the afternoon and advised an operation, but as the family had always employed a homeopath, we called in their family physician, Dr. Adams. The doctor could not satisfy himself that the patient had appendicitis at all, but gave his consent to an exploratory incision. The patient was removed to the City Hospital that evening and I made an incision, and found a large tense appendix covered with inflammatory lymph, and apparently ready to rupture at the apex. I removed it, the patient making a rapid recovery, and is at present in the best of health.

Now here is a case that had progressed that far in twenty-four hours, with but little pain and no alarming symptoms.

A short time previous to this case, I was called one Monday night to see a young lawyer in the absence of his own physician. Before entering the room, the patient's wife met me, and said that her husband was very nervous, and often imagined he had appendicitis, whenever he had pain in the abdomen. I found the patient suffering apparently from colic. He had no tenderness ; his abdominal muscles were lax ; his temperature and pulse were normal, and most of his pain was in the region of the transverse colon. Taking the history of the case into consideration, I did not think he was sick, and told the family so, ordered a laxative, leaving an anodyne to relieve his pain, and advising them to call in their own physician if he was not better in the morning. On the following Thursday his own physician operated on him, and found purulent peritonitis, resulting from a ruptured appendix, from which the patient died.

These cases convey their own lessons. They teach that we may find serious conditions in the abdominal cavity, demanding immediate operative interference, if we would save life, without classical symptoms.

Dr. L. McLane Tiffany, in the American Journal of the Medical Sciences, reports four cases of wounds of the peritonal cavity, and thinks the following propositions are justified :

" First.—A penetrating wound of the peritoneal cavity is not accompanied by symptoms commensurate with the extent of the injury.

Second.—Many fatal lesions may be present, and yet give rise to no marked symptoms.

Third.—Fatal lesions may exist, and yet shock be wanting.

Fourth.—The wound of entrance should be enlarged, and if the missile has entered the abdomen, a section is called for.

Fifth.—Operation is proper soon after the injury, before the peritoneum has become infected, or much blood lost."

In suspected peritoneal sepsis from any cause, the presence of a slight degree of jaundice is often a valuable danger signal, not to be ignored, but we must avoid placing too much reliance on the presence or absence of any symptom, but try to take a mental picture of each case on its own merits, supplementing symptoms with a careful physical examination.

Before closing, I wish briefly to call attention to another form of abdominal disease, from which its insidiousness, is, I am sure, often overlooked. I refer to tubercular peritonitis, which, one writer has said, can simulate anything from an ovarion tumour to pregnancy.

The following two cases occurring in my own practice will illustrate what I mean :

Last May, I was called to see a girl in a neighbouring village, who had been suffering for the past year from a slowly progressing enlargement of the abdomen. She had not menstruated for three months ; had no nausea or vomiting ; no pain ; appetite fair ; bowels regular ; temperature and pulse normal. After a careful physical examination of the abdomen, I diagnosed the case as one of ovarian tumour, and advised laparotomy. She came to the City Hospital and was apparently in very good condition, but on examining the lungs, I detected a small amount of fluid in the left pleural cavity, which I aspirated. This led me to change my diagnosis from ovarian tumour to that of probable tubercular peritonitis. Opening the abdomen a day or two later, I found the cavity full of serum, and the whole peritoneum studded with tubercles. The Fallopian tubes were very much thickened, and the ovaries somewhat disorganized. Nothing was removed. A glass drain was put in for twenty-four hours. The patient made a good recovery, and has apparently been greatly benefitted by the section. She has gained in weight and in strength, and her menstrual functions have returned.

The second case is of a similar nature.

A young girl, aged 22, came into my office complaining of a feeling of weight in the pit of the stomach after eating, and of indefinite pains in her side. She had consulted a physician in Pennsylvania, who told her she had gastric catarrh, and that her slight cough came from her stomach. The patient gave a history of slight loss of weight, and of general weakness. Having the previous case in my mind, I examined her very carefully, and found a small amount of fluid in the right pleural cavity, but could find no further evidence of lung trouble. On palpating the abdomen, I thought I detected fluid and

advised exploratory incision, asking her to see Dr. W. B. Jones to get his opinion. Dr. Jones agreed with me, so I operated a few days later, and found a condition as bad, if not worse, than the previous case. Mere drainage was followed by the same happy results, the patient apparently fully regaining her health.

If such results can be obtained in even these late cases, if it were possible to diagnose these cases earlier, might we not expect even a better and perhaps more permanent recovery ?